Hearing Innovations

Name____**Date**___________________________

Date of Birth___________________ **Social Security Number**____

Employed? Yes____ **If yes, where**____

No____ **If retired, from where**____

Insurance Company__________________**Contract #**______________**Group #**______ **Plan Code**__________________

Insurance Company Telephone Number___________________________

Married__________**Divorced**__________ **Single**_________ **Other**____________

Spouse's Name______________________________**OR Other Person's Name**__________________________________

Referred By________________________________**Family Physician**____

Email Address____

Health Information

	Yes	No
Have you had an examination by your physician in the last six months?	____	____
Examination by an ENT physician?	____	____
Diabetes?	____	____
High Blood Pressure?	____	____
Head or Neck Trauma?	____	____
Headaches?	____	____
Facial Numbness?	____	____
Pressure or Fullness in your ears?	____	____
Wax removed from you ears? How Often_______________	____	____
Dizziness or Vertigo?	____	____
Drainage from you ears?	____	____
Tinnitus? (ringing or head noise)	____	____

	Yes	No
Pain in or around your ears?	____	____
Ear Surgery?	____	____
Ear Physicians' Name _________________________________		
Punctured Ear Drum?	____	____
Family History of Hearing Loss?	____	____
Noise Exposure?	____	____
Acoustic Trauma?	____	____
CAT scan or MRI of Head or Ears?	____	____
Do you have Hearing Loss? Which ear is worse? R____L____	____	____
Have you had a Sudden Hearing Loss? When? ______________________	____	____
Do you wear Hearing Aids? Right_____ Left_____ Both _____	____	____
How long have you worn Hearing Aids? _________________________		